2 General Billing Information Contents

2.1 Introduction

This section covers the basic billing information providers need to submit claims and electronic adjustments to Idaho Medicaid. It describes Medicaid billing policies, how to submit Medicaid claims both electronically and on paper, how to check claim status, and where to get help with submitting claims. In addition, it describes the prior authorization process, third party liability, and adjustments (both electronic and paper).

Note: The provider handbooks are intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the Code or rules prevail.

2.1.1 Medicaid Billing Policies

Once enrolled, providers may begin billing for services rendered to Idaho Medicaid participants. Providers are not obligated to accept all Medicaid participants on an ongoing, day-to-day basis. Provider enrollment signifies only that a provider may bill Medicaid.

Providers should charge their usual and customary fee for services and submit those charges to Medicaid for payment consideration.

Providers must accept payment from Medicaid as payment in full for services rendered if they bill Medicaid for covered services. Non-covered Medicaid services can be billed to the participant. Medicaid requires the provider to inform the participant prior to rendering service if the service is not covered or if a particular covered service will not be billed to Medicaid, preferably in writing. **If** the participant agrees to pay for the service prior to the delivery of the service, then the provider may bill the participant for the entire amount of the fee.

If the participant has other insurance and the service is submitted for Medicaid payment, the provider must bill the third party insurance first, then bill Medicaid. In this case, the participant cannot be billed for the difference between the Medicaid allowed amount and the usual and customary charge.

2.1.1.1 Service Limitations

Medicaid policy restricts certain services. These restrictions are referred to as service limitations. Each procedure and revenue code may be reviewed for a variety of limitation criteria. Examples of these criteria are:

- Same provider or regardless of provider
- Time frame (yearly, calendar time period, or specific number of days)
- Number of dollars per timeframe
- Units
- Required justification (i.e., reports, test results, time of treatment, etc.)
- Pregnancy
- Age of participant
- Lifetime procedures

Some services with exceeded limitations may be covered with specific required justification or prior authorization. Read **Section 3** of this handbook carefully for any service limitations.

2.1.2 Timely Filing Limit

All claims must be submitted within one year (365 days) from the date of service. This is referred to as 'timely filing'.

2.1.2.1 Late Billing Documentation

All claim types must be submitted to Idaho Medicaid within twelve months (365 days) from the date of service regardless of the participant's eligibility status. The only exception is Medicare crossover claims (explained below). To determine if a claim is within twelve months from the date of service, use the Julian date of the original 15-digit internal control number (ICN). Refer to Glossary **Section 4.1.3** for a description of ICN.

When the date on the initial claim exceeds the twelve month limit for timely filing, Medicaid will deny the claim unless the claim contains proof of timely filing. The only proof of timely billing is the original ICN. This ICN must be documented in the remarks field on all electronic or paper resubmissions. The ICN must indicate that the original claim was submitted within twelve months from the date of service. If the ICN of the original claim is not indicated on the resubmitted claim, the claim will be denied regardless if it was originally billed timely.

The remarks fields for a paper claim form are:

- field 19 of the CMS 1500 claim form
- field 84 of the UB-92 claim form
- field 21 of the pharmacy claim form
- field 61 on the ADA Dental Form 1999/2000

For electronic claims the ICN can be indicated in the remarks field, except for pharmacy providers. Pharmacy providers must submit a paper claim.

If the client has a third party insurance carrier, the claim for services must be submitted to Idaho Medicaid within twelve months of the date of service regardless of the date of payment or date of the explanation of benefits (EOB) from the other insurance carrier. The only exception is for Medicare crossover claims. If a Medicare claim is received, Medicaid will consider the claim for payment if it is within six months of the date of the Medicare payment on the Medicare EOB.

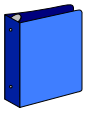
Claims for Idaho Medicaid clients who receive **retro-eligibility** must be submitted within twelve months of the date of service regardless of the date their eligibility was added.

Idaho Medicaid providers with a retro-active eligibility date must submit claims within twelve months of the date of service regardless of their enrollment date.

Claims for services requiring prior authorization (PA) from the Department or one of its agents must be submitted within twelve months of the date of service regardless of when the PA was issued.

For Medicare claims filed in a timely manner, Medicaid will consider claims for payment within six months of the date of payment or date of the EOB of the Medicare claim. Attach a copy of the Medicare Remittance Notice (MRN)

For more information



see **Section 2.5** for crossover billing

and submit the claim on paper or electronically if your software supports the transaction. Claims denied by Medicare for timely filing will in turn be denied by Medicaid as not being timely.

Adjustments to paid claims must be made within two years after the calendar quarter in which the payment was received. Adjustments can only be done on paid claims or paid claim details. Denied claims or claim details must be resubmitted as a new claim.

2.1.2.2 Claim Processing Timeline

Original Claims	Claim must be submitted within twelve months (365 days) of the date of service.
Denials	Claims should be resubmitted within twelve months (365 days) of the date of service. If more than a year has elapsed since the date of service, indicate original ICN # in the remarks field on claim
Other Insurance	Claim must be submitted within twelve months (365 days) of the date of service regardless of the date of payment or date of the EOB.
Client Retroactive Eligibility	Claim must be submitted within twelve months (365 days) of the date of service regardless of the date the client's eligibility was added.
Provider Retroactive eligibility	Claim must be submitted within twelve months (365 days) of the date of service regardless of the enrollment date.
Medicare Crossover Claims –denied or paid	Claim must be submitted within six months of the date of payment or date of the EOB of the Medicare claim. (Attach MRN.)
Adjustments for Paid claims	Claim must be submitted within two years after the calendar quarter in which the payment was received
Claims requiring Prior Authorization (PA)	Claim must be submitted within twelve months (365 days) of the date of service regardless of when the PA was issued.

2.1.2.3 Hospice Participants

Hospice care billings by non-hospice providers are considered on a case-by-case basis. Check with the Bureau of Medical Care for billing procedures. Any issues or questions concerning services for hospice participants regarding related or non-related charges should be referred to the hospice provider.

Bureau of Medical Care
P.O. Box 83720
Boise, ID
83720-0036
(208) 364-1836
FAX (208) 332-7280

2.1.2.4 Interpretation Services

Medicaid covers interpretation services for participants who are deaf or have Limited English Proficiency (LEP) and are receiving services from a fee-for-service provider. Medicaid payment will be made to the provider when it is necessary for the provider to hire an interpreter in order to communicate with a participant for whom they are providing a direct service. To locate an interpreter in your vicinity contact the ***Idaho Careline*** at (800) 926-2588.

For individuals who are unable to comprehend or directly influence their own treatment decisions due to age or disability, interpretation services may be

provided in order for the provider to communicate treatment instructions and guidance to the parent or guardian, as required to assure delivery of care.

Bill for interpretation services with the following procedure code:

8296A (Interpretive Services).

There is no difference in reimbursement if the interpreter is certified, partially certified, or non-certified and providing language services.

Payment for interpretation services will not be made to providers who cost audit settle with the Department. These services are considered to be included in the provider's cost of doing business. This includes providers such as Hospitals, Home Health Agencies, Rural Health Clinics, and Long Term Care Facilities.

Refer to Medicaid Information Release MA03-54 for more information.

Information Releases are available on the Internet: **www2.state.id.us/dhw/medicaid/inf/mir.htm**

2.1.3 Participant Billing Information

The participant's name is used in conjunction with the Medicaid Identification Number (MID) for identification when submitting claims. To avoid errors, verify participant eligibility every time services are rendered.

2.1.3.1 Medicaid Identification Number (MID)

Every Idaho Medicaid participant (including children) receives a unique 7-digit identification number. The Medicaid Identification Number (MID) is the only number accepted for processing claims. When entering the number on the claim form, do **not** use:

- participant's Social Security number
- another family member's MID
- any letters, symbols, or hyphens

2.1.3.2 Participant Name

It is important to enter the participant's name accurately. EDS electronic billing software (PES) and a HIPAA-compliant Point of Service (POS) device give a printed record of the spelling of the participant's name as it is on file with Medicaid. Common errors that are made when entering the name on the claim form include:

- spelling mistakes, including not using participant's preferred spelling
- name not entered in correct order or the participant may use a hyphenated last name
- when entering a two word last name, not starting with the lead name (Example Van S. Glen Garry, "Glen" is the beginning of the last name **not** Garry
- use of a nickname from the provider's records instead of the proper name on file with Medicaid
- participant name has been changed and the participant has not updated his/her records with Medicaid or the provider
- parent's name used for minor child with a different last name

- typing errors

2.1.4 Provider Signature and Number

All paper claims must have a valid provider signature and the 9-digit provider number. Claims that are not signed and/or do not have a provider number are returned, whenever possible.

2.1.4.1 Signature on File

Providers must sign every claim form **or** complete a signature-on-file form. This form is used to submit paper claims without a handwritten signature and/or to submit electronic claims. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures. For more information about the signature-on-file form see **Section 1.1.4**.

FORM AVAILABLE: a signature-on-file form is included in the Forms Appendix of this handbook.

2.1.4.2 Provider Number

No claim can be processed without a valid Idaho Medicaid provider identification number. At the time of enrollment, each individual and group provider receives a unique number to use in the Idaho Medicaid program. Provider identification numbers always have 9 digits with **no** spaces or hyphenation. Do **not** use a Social Security or FEIN number. Do **not** use a group number when an individual provider number is required, or vice versa.

Healthy Connection referral numbers are required to process claims for referred services. Please refer to your specific program handbook for the correct field and location to document this information on your specific billing form.

2.2 Claims Submission

Providers may submit claims either electronically (EDI) or on paper (hardcopy).

2.2.1 Electronic Claims Submission

Electronic Data Interchange (EDI) is the computer-based system that processes electronic claim transactions. Unless an attachment is required, all claims can be billed electronically using the free EDS PES billing software, a billing service or agency clearinghouse, or other vendor software (that has successfully tested with EDS). Unless they are using EDS billing software, all providers must have their software vendor or clearinghouse contact EDS to test software before claims can be submitted.

Electronic submission allows faster and more efficient claim submission and processing. Handling time, costs, and errors are reduced, eliminating the problems in processing that result in payment delays. Electronic claims can be submitted 24 hours a day, 7 days a week.

All providers, except retail pharmacies, who bill electronically, must submit claims in the HIPAA-compliant 837 transaction format, version 4010A1. **Retail pharmacy providers** who bill prescription drugs electronically must use the HIPAA NCPDP 5.1 format.

Electronic claims that are not in the correct HIPAA-compliant format will be rejected.

Because providers use a variety of different billing software, it is not possible to give exact information on how to complete any specific electronic eligibility or claim form. Providers can review the *Idaho Provider Electronic Solutions Handbook* (included on the Idaho Medicaid CD) for a general example of eligibility and billing software.

Note:
A HIPAA-formatted electronic claim for professional, dental, and institutional services is called an **837 transaction**.

A HIPAA-formatted electronic claim for retail pharmacyl services is called an **NCPDP transaction**.

A HIPAA-formatted electronic remittance advice is called an **835 transaction**.

2.2.1.1 EDS Billing Software (PES)

EDS has developed and distributed software to all Idaho Medicaid providers to submit claims and check participant eligibility. The EDS software is also referred to as Provider Electronic Solutions (PES).

PES contains forms to submit electronic transactions by diskette or modem. Electronic transactions include eligibility verification, and submission of professional, dental, institutional and pharmacy claims. The software comes loaded with commonly used lists, for example, place of service values and other insurance carrier information. In addition, the user can create lists of information regularly used in forms such as participant names and procedure codes. The software also generates reports to track the information submitted within the claims.

The system requirements for EDS billing software (PES) are:

Minimum	Recommended
Pentium II with CD-ROM	Pentium II with CD-ROM
Windows 2000/XP	Windows 2000, NT, ME, XP
MS Internet Explorer 5.5 or greater	MS Internet Explorer 5.5 or greater
64 Megabytes RAM	128 Megabytes RAM

Minimum	Recommended
800 X 600 Resolution	1024 X 768 Resolution
28.8 baud rate modem or faster is preferred	33.6 baud rate modem or faster
100 MB Free Hard Drive Space	100 MB Free Hard Drive Space
CD-ROM	CD-ROM
Printer with 8pt MS Sans Serif is preferred	Printer with 8pt MS Sans Serif

2.2.1.2 Vendor Software and Clearinghouses

Providers can use electronic claims submission software from other vendors after it is tested to comply with the Idaho Medicaid EDI system. Contact the EDS Help Desk for assistance in running test claims before submitting large batches for the first time with new or upgraded software.

Providers who wish to bill electronically and who bill to more than one insurance carrier should consider using a clearinghouse. Clearinghouses are private companies that handle insurance claims for multiple providers. The advantage for the provider is that claims are keyed only once for the clearinghouse. The clearinghouse then forwards the claim to the appropriate insurance carriers (including Idaho Medicaid).

EDS will furnish the specifications, free of charge, to any vendor upon request. The specifications assist the vendor in duplicating the program requirements to allow a provider to obtain the same information available as using software supplied by EDS. All vendor software must have successfully tested with EDS before use. Once the vendor or clearinghouse has successfully transmitted sample data to the Idaho Medicaid system, providers using their services may begin using the vendor software or clearinghouse to submit claims.

Providers, vendors, and clearinghouses should contact EDS at (800) 685-3757 and request the *TECHNICAL SUPPORT* team to arrange testing. When testing has been completed, claims may be submitted for processing. For all other questions, providers may contact their regional Provider Relations Consultant.

FORM AVAILABLE: An Electronic Claims Submission and Authorization Form is included in the Forms Appendix of this handbook.

It can also be used to request free software from EDS.

2.2.1.3 Electronic Claims Submission Agreement

All providers who wish to bill electronically must submit an Electronic Claims Submission Agreement and receive a BBS submitter ID and password from EDS. See the **Forms Appendix** for a copy of the agreement.

2.2.1.4 HIPAA-Required Data Elements

When billing electronically, providers must complete all HIPAA-required data elements; however, not all of the information is used by Idaho Medicaid in claims processing. The following HIPAA-required data elements for an electronic HIPAA 837 claim submission are not used by Idaho Medicaid:

- Release of Medical Data
- Benefit Assignment
- Patient Signature
- SSN
- Tax ID Number and Qualifier
- Provider ID Qualifiers
- Entity Type Qualifiers
- Provider and Participant Address
- Participant ID Qualifier
- Participant DOB
- Participant Gender

2.2.2 Paper Claim Forms

Several different types of claim forms are used to bill services to Medicaid. All paper claims are electronically scanned for processing. The printed versions of the claim forms are “machine readable”. As such, they are printed using special paper, special color inks, and within precise specifications. For this reason, only **original**, **color forms** can be used for scanning. Forms that cannot be scanned are returned to the provider.

To ensure that claims are scanned correctly, follow these guidelines:

2.2.2.1 Completing the Form

- Use an original, **color** claim form. Black copies cannot be scanned.
- Check **Section 3** in this handbook for the required fields. When billing Medicaid there is no need to enter data into fields that are not required.
- Use **black** ink.
- Use a typewriter with a good ribbon or a printer with a good ink cartridge. Change the ribbon or ink source if the print is too light.
- When using a typewriter or printer, make sure the form is lined up correctly so it prints evenly. Claims cannot be processed when the information is not in the correct field.
- If completing the form by hand, print neatly.
- Be sure to stay within the box for each field.
- When entering an **X** in a check-off box, be sure that the mark is centered in the box.
- Use correction tape to cover errors.

- Use yellow or pink highlighting pens to mark information on a claim. Other colors appear as a black bar and the text is obscured.

2.2.2.2 Mailing the Form

- Do not staple any attachments to the form. Check **Section 3** of this handbook to see if an attachment is required. Providers are urged to bill electronically when no attachments are required.
- Do not fold the form. Mail it flat in a 9 x 12 envelope (minimum size).

  Mail To: P.O. Box 23
  Boise, ID 83707

- Send correspondence in a separate envelop or mark the outside of the claim envelop, "Correspondence Enclosed"

2.2.2.3 Entering a Provider Identification Number on a Paper Claim Form

Professional Claims submitted on the CMS-1500 form:

Professional groups:

- Enter the individual performing provider's Idaho Medicaid Provider Identification Number in field 24K for each detail line.
- Leave the space blank next to PIN# in field 33.
- Enter the group Idaho Medicaid Provider Identification Number next to GRP# in field 33.

Professional individuals:

- Enter the individual Idaho Medicaid Provider Identification Number next to PIN# in field 33.
- It is not necessary to enter the individual performing provider number in field 24K.

Dental Claims submitted on the ADA 1999 (2000) form:

Dental groups:

- Enter the group Idaho Medicaid Provider Identification Number in field 44, Provider ID #.
- Enter the individual performing provider's Idaho Medicaid Provider Identification Number in field 59, Admin Use Only for each detail line.
- Enter the group Idaho Medicaid Provider Identification Number in field 44, Provider ID #.

Dental individuals:

- Enter the individual Idaho Medicaid Provider Identification Number in field 44, Provider ID #.

2.2.3 Attachments

Attachments are additional documentation required to submit a claim for processing. Attachments may include:

- Third Party Explanation of Benefits (EOB)
- Explanation of Medicare Remittance Notice (MRN)
- Certificate of Medical Necessity (CMN)
- Pharmacy prescription
- Consent forms
- Manufacturer's Invoice

Electronic Attachments:

Idaho Medicaid providers will not be able to submit attachments electronically until the federal rule is finalized.

Providers will be notified via the Medicaid Information Release process.

If no attachments are required, **then** consider submitting the claim electronically.

If a claim has an attachment, **then** do not staple or clip it to the claim. Place it behind the claim form.

If multiple claims refer to the same attachment, **then** make separate copies of the attachment for each claim.

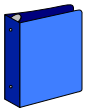
If multiple claims are sent together, **then** stack the claims with each claim followed by its own attachment(s).

If an attachment has information on both sides of the page, **then** make a copy of the backside and include it with the claim.

If an attachment such as a sales receipt is on a small slip of paper, **then** copy or tape it onto an 8½ by 11 inch piece of paper.

It is **not** necessary to include the Medicaid remittance advice as an attachment.

For more information



see **Section 3** for completing a claim.

2.2.3.1 Examples of Documentation Necessary for Billing

Actual Example	Required Documentation	Solution
3 claims submitted for the same participant with 1 EOB included with the claims.	1 copy of the EOB for each claim	Submit all 3 claims on 1 claim form and include 1 EOB. OR Submit 3 claims and include 1 EOB with each claim.
4 corrected claims submitted that had previously been denied. RA explaining why claims had previously been denied is included.	none	Do **not** include RA with claim. When the date on the claim exceeds the timely fling limit (1 year from date of service) enter the ICN from the RA in the comment field of the claim.
3 claims submitted for the same participant and 1 copy of a Healthy Connections referral included.	none	Submit 1 claim for all the services and enter the HC referral number in correct field.
2 CMS claims submitted, the first is marked *'continued',* and 1 attachment is included to explain the use of a 'dump' code for a lab test.	none	Total each claim separately and enter the name of the lab test in field 19.
2 claims submitted with 1 prescription attached.	1 copy of the prescription for each claim.	Include 1 prescription copy with each claim form.

2.2.4 Claim Status

There are three types of claim status: pended, denied, and paid. Providers can determine the status of their claims three ways: through the weekly remittance advice, by calling MAVIS, and with the 276/277 electronic claim status request and response transaction. **Note:** The 276/277 electronic claim status request and response is not a transaction supported by PES.

Remittance Advice

See Section 4 in this handbook for information on remittance advices.

MAVIS Inquiry

Providers can check the status of electronic and paper claims sent to EDS for processing by calling the Medicaid Automated Voice Information Service (MAVIS) and selecting the Claims Information option. For more information on how to access MAVIS and check claim status, refer to the MAVIS Appendix.

Electronic Inquiry

Effective February 23, 2004, Idaho Medicaid supports the HIPAA transaction known as the 276/277, Electronic Claim Status Inquiry and Response. This transaction allows providers to electronically inquire on the status of claims and requires health plans to return an electronic response. A claim status inquiry (276) can be sent with only a claim number or with the client Medicaid ID number, client last and first name, gender and date of birth. Claim category and status codes will be returned in the claim status response (277). EDS will process the 276/277 HIPAA transactions on a daily basis.

Providers should contact their software vendor or clearinghouse to determine if they support the claim status inquiry and response. PES, the Idaho Medicaid claims and eligibility software, does **not** support the 276/277 transaction.

2.3 Prior Authorization

2.3.1 Overview

Federal regulations permit Medicaid to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or participants, or easily result in excessive and uncontrollable Medicaid costs. Prior approval is required *before* certain services are delivered to a participant. DHW and private contractors maintain the PA process. All claims for all services that require prior authorization must include the PA number on the claim whether the claim is electronic or paper.

For PA addresses and telephone numbers, see the **Idaho Medicaid Directory** at the beginning of this handbook.

Depending on the service, prior authorization is available from:

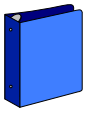
- Division of Medicaid's Central Office
- Regional Developmental Disabilities Program
- Medicaid Non-Emergent Transportation
- Regional Medicaid Services (RMS)
- Regional Mental Health Authority (RMHA)
- Qualis Health (a private contractor)

It is the provider's responsibility to verify the participant's eligibility on the date of service and request any required prior authorization. See **Section 3** of this handbook for more detailed information on specific services that require prior authorization. **Note:** Receiving a prior authorization for services does not guarantee payment. The client must be eligible on the date authorized services are rendered.

DHW requires prior authorization for the following general areas of service:

- Case management services
- Home and Community Based Waiver Services for the following waivers:
  - Developmental Disabilities
  - Aged and Disabled
  - Traumatic Brain Injuries
- Personal care services
- Some durable medical equipment (DME) purchases and rentals
- Cosmetic and reconstructive surgery
- Miscellaneous DME supplies totaling over $100.00 per month
- Some prosthetics and orthotics
- Selected hospital inpatient/outpatient procedures
- Selected optometric services
- Selected prescription drugs
- Some physical therapy services
- Selected surgical procedures
- Services/procedures identified as necessary in an EPSDT screen that are outside the scope of Idaho Medicaid coverage, such as private duty nursing

For more information



see **Section 3** for questions concerning prior authorization for a particular services

For information on prior authorization for former **CHIP-B** participants see **Appendix B**, **Section B.5**.

- Some dental surgery and items
- Surgery related to obesity
- Transplants
- Transportation by an ambulance or individual/commercial transportation provider for non-emergency Medicaid covered services from an Idaho Medicaid medical provider
- Any urgent/emergency inpatient or outpatient treatment where the procedure or diagnosis code appears on the select pre-authorization list must be reviewed by Qualis Health within one working day of admission. Those surgical procedures on the select pre-authorization list must be authorized regardless of the place of service. The diagnoses on the select pre-authorization list are for inpatient only.

2.3.2 Medicaid Prior Authorization

To render a service that requires Medicaid prior authorization, write a letter to Medicaid and attach documentation justifying the medical necessity of the procedure.

Note: On PA Requirements

PA numbers must be included on **all** claims for services that require prior authorization.

Professional and Dental providers can use more than one PA on electronic claims.

Direct all requests for prior authorization to the appropriate contractor or Department unit as listed in Section 3. The requests should include:

- Participant name and MID number
- Signed physician's order
- A list of all items and a price quote for each
- Prescriber's statement of diagnosis and medical necessity for applicable drugs
- Requesting provider
- If a Healthy Connections (HC) participant, include the PCP's referral number

Medicaid issues a written notification of authorization or denial for all written requests for PA. A PA number is assigned to all approved PAs. Enter the PA number in the designated field on the claim; do **not** attach the PA letter. Professional and Dental electronic claims may include multiple PA numbers on each claim.

The PA letter indicates the length of time the authorization is valid. The dates of service being billed must occur on or after the start date and on or before the expiration date indicated on the PA letter. If the prior authorization expiration date occurs before services are provided, a new prior authorization must be requested. To prevent a disruption or break in service to the participant, request prior authorization as soon as the need for additional services is identified.

Claims that require prior authorization may be submitted electronically. Note the PA number on the claim form screen in the appropriate field and use the procedure codes and units of service as authorized on the PA letter.

Dental
Dental PA requires submission of the general or orthodontic prior authorization forms to the Medicaid Dental Consultants. See **Section 3** of the **Dental** Program provider handbook for specific PA request procedures.

Pharmacy
Pharmacy providers apply for PA from the Division of Medicaid. The Division returns the PA letter with a PA number; the provider submits the claim with the PA number to EDS. See **Section 3, Pharmacy**, for more information on

the pharmacy PA process or the Pharmacy Program Information on the Internet at
http://www2.state.id.us/dhw/medicaid/providers/pharmacy.htm.

All Providers
Whether billing electronically or on paper, all providers who bill services requiring **prior authorization (PA)** must include the PA number on their claims. If a claim doesn't have a prior authorization number on it or does not match the prior authorization on file, then the claim will be denied.

2.3.2.1 Electronic Billing with PAs

For PA addresses and telephone numbers, see the **Idaho Medicaid Directory** at the beginning of this handbook.

Idaho Medicaid allows professional and dental providers who submit electronic claims to include multiple PA numbers on one claim. When necessary, providers can send PA numbers at both the header and detail level. (See examples as follows)

- If a provider sends a PA at the header and no PA at the detail, the header PA will apply to the whole claim.
- If a provider sends a PA at the detail and no PA at the header, the PA number will apply to that detail only.
- If a provider submits multiple services and sends a PA at the header, which applies to some of the services, and a different PA at the detail, Medicaid will process the PA at the detail first against the detail service. Medicaid will process the remaining details using the header PA.

Note: Paper claims (regardless of provider type), electronic institutional, and electronic pharmacy claims can use only **one** PA for each claim.

2.3.2.2 PA Number Format on Claims

When billing electronically using Idaho Medicaid PES software, add enough zeros at the **beginning** of the number to make it eight digits. *Example:* 654321 becomes 00654321. Do **not** add zeros at the end; it will cause the claim to deny.

When completing a paper claim, enter the PA number in the appropriate field exactly as it is given on the prior authorization notification. Do not add zeros.

2.3.3 Regional Medicaid Services (RMS) Prior Authorization

The Regional Medicaid Services unit is responsible for prior authorization for:

- Personal Care Services
- Home and Community Based Waiver Services for the elderly and persons with physical disabilities
- Waiver Services for persons with traumatic brain injuries
- PCS case management
- Private duty nursing for children under the EPSDT program

Note: Private duty nursing is authorized by the RMS for participants under age 21.

If completion of a form is required for the request, the RMS will provide the appropriate form.

The RMS unit issues a written notification of prior authorization or denial for all submitted requests. A prior authorization number is assigned to each request. Enter the PA number in the appropriate field on the CMS 1500 claim form or the electronic claims screen. There is no need to attach the prior

authorization notice to the claim when billing, however the claim must match the prior authorized procedure codes, authorized dates of service and diagnosis exactly.

2.3.4 Developmental Disabilities (DD) Program Prior Authorization

The Case Manager submits an Individual Support Plan (ISP) to the Regional DD unit to request prior authorization (PA) for waiver services for adult development disabilities service coordination and EPSDT service coordination. The ISP form may be obtained from the regional DD unit.

The ACCESS unit issues a written notification of PA or denial for all submitted requests. A PA number is assigned to each request. Enter the PA number in the appropriate field on the CMS 1500 claim form or the electronic claims screen. There is no need to attach the PA notice to the claim when billing, however the claim must match the prior authorized procedure codes, authorized dates of service and diagnosis exactly.

The Medicaid participant or participant's representative must obtain PA before the provider renders services.

Transportation PAs are available by calling:

(208) 334-4990
(800) 296-0509

or

FAX the request to:

(800) 296-0513

2.3.5 Medicaid Transportation Prior Authorization

Call the Medicaid Transportation to request prior authorization (PA) of the following services:

- In state and out-of-state, non-emergency medical transportation and related necessary expenses to receive covered medical care and treatment, if no other free resources
- Lodging and meals for participant and attendant when necessary
- Requests for prior authorization must be received at least 24 hours prior to the time requested services are to be provided.

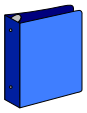
2.3.6 Quality Improvement Organization Prior Authorization

The Division of Medicaid contracts with Qualis Health (formerly PRO-West), a quality improvement organization to conduct medical necessity reviews on a pre-admission basis for selected diagnoses and procedures. Qualis Health also conducts concurrent review of all inpatient admissions that exceed a specified number of days and retrospective reviews when necessary. For specific instructions on how to request these reviews, see the QIO Provider Manual (on the web at www.qualishealth.org/medicaid.htm) or contact the QIO directly at:

Qualis Health
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400

Telephone: (800) 783-9207
FAX: (800) 826-3836

For more information



see **Qualis Health Provider Manual 2003** available on the Idaho Medicaid Provider Resources CD

If transportation services are requested for an out-of-state admission, they must be prior authorized by Medicaid Transportation.

See **Section 3** for more billing information using QIO approvals.

2.3.7 Requests for Reconsideration and Appeals

Providers and participants may appeal a PA decision made by the Department or its designee, by following these steps:

Step 1 Carefully examine the *Notice of Decision for Medical Benefits* to ensure that the service(s) and requested procedure code was actually **denied** (see "Status"). Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider or participant feels that an inappropriate denial of service has occurred, the next step is to submit a written *Request for Reconsideration*.

Step 2 **Request for Reconsideration**
Prepare a written *Request for Reconsideration*, which includes any **additional** extenuating circumstances and **specific** information that will assist the authorizing agent in the reconsideration review. Resubmit to the authorizing agent within 28 days from the mailing date of the *Notice of Decision for Medical Benefits*.

Upon completion of it's reconsideration, the department will issue a second *Notice of Decision for Medical Benefits.* If the provider or participant disagrees with the PA reconsideration decision made by the Department or its designee, they may file a Request for Appeal. The provider or participant has 28 days from the mailing date of the second, "Notice of Decision for Medical Benefits", to submit a formal appeal.

Step 3 **Request for Appeal**
To submit a written request for an appeal of the decision, follow the steps below. Documentation may be faxed but the fax must be followed with copies of original documents in the mail.

Step 1 Prepare a written request for an appeal that includes:

- a copy of the Notice of Decision For Medical Benefits from the authorizing agent
- a copy of the Request for Reconsideration from the provider/participant
- a copy of the second Notice of Decision for Medical Benefits from the authorizing agent showing that the request for reconsideration was performed
- an explanation of why the reconsideration remains contested by the provider/participant
- copies of all supporting documentation

Step 2 Mail the request and additional information to:

Hearings Coordinator
Idaho Department of Health and Welfare
Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036
FAX: (208) 332-7347

QIO Appeals
The advisory letter sent from the QIO to physicians and hospitals gives two types of appeal options, expedited and standard. Appeals for non-certification or partial certification decisions must be completed with Qualis Health review before submitting an appeal to the Department's Hearings Coordinator.

- Expedited Appeal: An expedited appeal must be requested by telephone, fax or in writing within two business days after notification. Qualis Health will complete the appeal within two business days from the receipt of your request. If you disagree with the results of the expedited appeal determination or have not submitted one, you have the option of requesting a standard appeal.

- Standard Appeal: The standard appeal request must be submitted within 180 days of receipt of the advisory letter from Qualis Health. Another peer physician will review the medical records and any new information you submit. You will be notified of the determination within 30 days. If you disagree with the final decision, you may then request a Department appeal, also referred to as a contested case hearing appeal.

- Department Appeal: A contested case hearing may be requested from the Department after the appeal process is exhausted with Qualis Health. The appeal must be received in writing by the Department's Hearings Coordinator, Administrative Procedures Section (see address above), within 28 days from the mailing date of the advisory letter. A copy of the final determination letter from Qualis Health attached to your appeal will help expedite your request. You will be notified in writing by a Hearing Officer to set up a date, time and location of for the hearing.

2.4 Third Party Recovery (TPR)

2.4.1 Overview

This section covers the third party recovery (TPR) situations that may apply to providers working with Idaho Medicaid participants. It briefly describes how EDS processes third party recovery claims. In accordance with federal regulations 42 CFR-433.135-139, the Division of Medicaid or its designee must take all reasonable measures to determine the legal liability of third parties to pay for medical services under the plan.

A third party is any insurance company, private individual, corporation, or business that can be held legally responsible for the payment of all or part of the medical or dental costs of a participant. Third parties could include:

- group health insurance
- workers' compensation
- homeowners' insurance
- automobile liability insurance
- non-custodial parents or their insurance carriers
- an individual responsible for a Medicaid participant's injury (a person who committed an assault on a participant, for instance)

Federal regulations require providers to bill all known insurance companies before submitting a claim to Medicaid. See **Section 2.4.2, Exclusions**, for the exceptions to this requirement.

To verify other insurance information, call MAVIS

383-4310 from the Boise calling area

(800) 685-3757 outside the Boise calling area

24 hours a day, 7 days a week

2.4.1.1 Participant Responsibility

The provider must accept the Medicaid allowed amount as payment in full. The provider cannot bill the participant for any balance remaining after the primary insurance and Medicaid have both paid.

2.4.2 Exclusions

Services excluded from TPR requirements are:

- early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program services
- prenatal
- non-emergency medical transportation
- personal care services
- mental health
- developmental disability
- health related services provided by Idaho Public School Districts

Providers who bill for these services are not required to bill the third party before billing Medicaid.

2.4.3 Determining Other Insurance Coverage

Use MAVIS, a HIPAA compliant point of service device, submit an inquiry through EDS billing software (PES), or other successfully tested vendor software to determine if a participant has other insurance coverage before billing Idaho Medicaid. The system lists the name of the insurance company

if it is one of the top 100 companies identified by Idaho Medicaid and the type of coverage. If there is other insurance coverage, note the information on the other insurance carrier and bill the other insurance before billing Medicaid.

Refer to **Section 2.4.3.1** for a complete listing of the TPR coverage codes and their descriptions.

Refer to **Section 2.4.3.2** for a listing of the top insurance companies identified by Idaho Medicaid.

2.4.3.1 TPR Coverage Codes

Code	Description
0001	Full Coverage
0002	Full Coverage No Dental
0003	Full Coverage No Dental No Drugs
0004	Full Coverage No Vision
0005	Full Coverage No Dental No Vision
0006	Accident Only Policy
0007	Hospital Only Policy
0008	Surgical Policy
0009	Accident & Hospital Only
0010	Cancer Only Policy
0011	Dental Only
0012	Drug Only
0013	Vision
0014	Medicare Part A
0015	Medicare Part B
0016	Medicare Supplement - No Drug
0017	Full Coverage with Dental, without Drug
0018	Medicare Supplement with Drug
0019	Full Coverage - No LTC
0020	Full Coverage - No Dental - No LTC
0021	Full Coverage - No Drug - No LTC
0022	Full Coverage - No Vision - No LTC
0023	Full Coverage - No Dental - No Drug - No LTC
0024	Full Coverage - No Dental - No Vision - No LTC
0025	Full Coverage - No Dental - No Vision - No Drug
0026	Full Coverage - No Dental - No Vision - No Drug -No LTC
0027	Medicare HMO
0029	Unknown
0038	Air Ambulance Coverage
0039	LTC/Nursing Home Coverage
0040	Full Coverage No Vision No Drug and LTC

2.4.3.2 TPR Carrier Codes

Carrier Code	Carrier Name
00010	Utah-Idaho Teamsters Health & Welfare
00011	Railroad Employees
00012	Blue Shield of Idaho (Regence)
00014	Mail Handlers
00020	Palmetto Government Benefit Admin
00025	Oregon Life & Health
00037	Bankers Life & Casualty
00038	Regence Life And Health
00039	Blue Cross Of Idaho
00041	Blue Cross Of Washington/Alaska
00051	Union Bankers Insurance
00053	Deseret Mutual Benefit
00058	First Health
00059	TPM / Timber Product Management
00062	N A L C Health Benefit
00063	Lamb-Weston Gr Claim
00068	Globe Life & Accident
00070	I E C / Ameri-Ben Solutions
00074	Administration Service
00077	Medical Services Corporation (MSC)
00079	Mutual Of Omaha
00083	Physicians Mutual
00102	GEHA
00124	First Health
00148	Iowa Benefits
00158	Blue Cross Of California
00160	Great West Life
00162	Lamb Weston
00173	Group Health Northwest
00192	Blue Cross Blue Shield Of Utah
00194	Group Health Northwest
00197	Jensen Administrative Services
00213	Blue Cross Of Idaho
00221	Wall-Mart Benefits
00228	CIGNA
00246	Highmark B C B S of Pennsylvania
00253	Boise Cascade Insurance
00266	CIGNA
00296	Health Med / Qualmed
00302	United Health Care
00303	First Health
00307	Washington-Idaho Operating Engineer
00310	First Health HP Employees
00314	Blue Cross of Pennsylvania
00337	HMO Blue

Carrier Code	Carrier Name
00347	United Health Care
00364	Mega Life & Health
00367	United Health Care
00380	AETNA/Prudential
00433	United Health Care
00437	AARP
00447	AETNA
00485	MEGA Life & Health
00489	Combined Insurance
00504	Educators Mutual
00555	AETNA
00577	Lincoln National
00597	Principal Financial/JR Simplot
00615	I H C
00639	Retail Clerks Trust
00751	CIGNA
00752	Heller Associates
00813	Principal Financial
00821	First Health RX (Alta RX)
01110	Benesight/Third Party Administrator
MEDA	Medicare Northwest
MEDB	Medicare CIGNA
RRA	United Healthcare
RRB	United Healthcare

2.4.4 Processing TPR Claims

After receiving either a partial payment or a denial from an insurance company, submit the claim to Medicaid for payment consideration along with a copy of the explanation of benefits (EOB).

- **If** the insurance payment is **more than 40%** of the billed amount, no EOB is required for the claim.
- **If** the insurance payment is **less than 40%** of the billed amount, the provider must bill on a paper claim and a copy of the insurance company's explanation of benefits (EOB) must be included with the claim.
- **If** the insurance is **Medicare,** a Medicaid Remittance Notice (MRN) is always required.

When submitting the claim to Medicaid, verify that the dates of service, units, and charges are the same on the primary insurance EOB and on the claim to Medicaid.

If the other insurance carrier paid no services on the claim, submit the claim to EDS for processing. A copy of the other insurance company's EOB must be attached to the claim to document the other insurance company's denial. The denial must be valid before the claim can be processed.

A paper EOB from the other insurer is included with paper claims, including the EOB message from the other insurance. Since there are hundreds of insurers, each with their own coding system, Idaho Medicaid cannot process a claim unless the EOB number and message is included with the paper claim.

Fill in the other insurance paid amount in the appropriate field of the claim. If the insurance pays at zero, “0.00” must be recorded in the appropriate field or the claim will be denied. These claims can be submitted electronically with the Medicaid third party recovery Adjustment Reason Code (ARC) in the appropriate field.

2.4.4.1 Electronic Third Party Claims

HIPAA Adjustment Reason codes replace the Third Party EOB Codes that were formerly used on electronic third party claims.

These codes are used to explain the payment of benefits for a claim. After the claim has been submitted to the primary insurance carrier and processed, these codes are used to explain how the claim was processed. Adjustment Reason codes (ARC) describe the action taken by the other payer. For electronic claims, the current ARC code is required on all TPR transactions.

Submit paper claims with the required EOB which includes the ARC codes. Use the code that best explains how benefits were processed (paid or not paid).

Further information can be obtained online at:
http://www2.state.id.us/dhw/medicaid/inf/2002/02med34.htm
or contact EDS at (800) 685-3757.

2.4.4.2 Adjustment Reason Codes

Code	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

Code	Description
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	OPEN
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
41	OPEN
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
46	OPEN
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	OPEN
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a `medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Code	Description
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	OPEN
64	OPEN
65	OPEN
66	Blood Deductible.
67	OPEN
68	OPEN
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
71	OPEN
72	OPEN
73	OPEN
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	OPEN
78	Non-Covered days/Room charge adjustment.
79	OPEN
80	OPEN
81	OPEN
82	OPEN
83	OPEN
84	OPEN
85	Interest amount.
86	OPEN
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	OPEN
93	OPEN
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	OPEN
99	OPEN
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.

Code	Description
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Payment reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	OPEN
121	Indemnification adjustment.
122	Psychiatric reduction.
123	OPEN
124	OPEN
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied -- Prior processing information appears incorrect.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.

Code	Description
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g., preferred product/service.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	OPEN
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B2	OPEN
B3	OPEN
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because `New Patient' qualifications were not met.
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	OPEN
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	OPEN
B22	This payment is adjusted based on the diagnosis.

Code	Description
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
W1	Workers Compensation State Fee Schedule Adjustment

2.4.4.3 TPR Fields on Paper Billing Forms

This table lists all the paper claim forms used by Idaho Medicaid and the fields used for TPR by number.

Claim Form	Usual and Customary	Total Charges	Other Insurance	Balance Due	Comments
CMS 1500	24F.	28.	29.	30.	19.
	$ Charges	Total Charge	Amount Paid	Balance Due	Reserved for local use
UB-92	47.	47.	54.	55.	84.
	Total Charges	Enter the revenue code 001 and the total of all claim charges	Prior Payments	Est. Amount Due	Remarks
Pharmacy	(not used)	18.	19.	20.	21.
		Total Charges	Other Insurance Amount	Balance Due	Compound Drug Information
Dental (1999)	59.	59.	59.	(not used)	61.
	Fee	Total Fee	Payment by Other Plan		Remarks for Unusual Services

2.4.4.4 Unacceptable Denial Codes

A billing or timeliness error is not considered a “valid denial”. The following are examples of denials that will **not** be accepted for either paper or electronic claims:

- claim lacks information that is needed for adjudication
- patient cannot be identified as our insured
- claim filed past filing time limit
- duplicate of a previously submitted claim

2.4.4.5 Medicaid Participation

If the insurance company made a payment toward the services, enter the amount of the payment in the appropriate field on the claim form. Medicaid will pay the balance of any remaining covered charges up to, but not exceeding, the amount allowed by Medicaid.

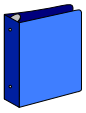
The following are examples of an insurance company (including Medicare) payment on Medicaid covered services.

Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	80.00
Medicaid Payment	**0.00**

Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	50.00
Medicaid Payment	**30.00**

Provider Billed Amount	$100.00
Medicaid Allowed Amount	80.00
Insurance Payment	90.00
Medicaid Payment	**0.00**

For more information



see **Section 2.5** for crossover claims

2.4.5 Split Claims

Sometimes claims are billed to other insurance with more lines than will fit on the Medicaid **paper** claim form. To create a matching claim, the claim must be 'split'.

If the other insurance's EOB has more detail lines than will fit on the claim form, divide the claim into two or more separate claims. Submit the first lines on one claim form and the remaining lines on additional claim forms.

Write '*Split Claim'* in field 19 of the CMS 1500, field 84 of the UB92, or field 61 of the 1999 ADA claim forms. Total each claim. Attach a separate copy of the EOB to each split claim.

Pro-rate the third party payments to match the lines billed.

Include a separate copy of the EOB with each split claim.

When billing **electronically**, it is not necessary to split a claim unless the provider is submitting more than the maximum number of details allowed on the claim.

Dental claims:	up to 50 details
Professional claims:	up to 50 details
Institutional claims:	up to 999 details

Note
ICD-9-CM codes **800** to **999** are injury diagnoses. For more on using diagnosis codes in this range, see **2.4.6.2 Injury Diagnosis** before submitting your claim. This helps prevent an unnecessary claim denial.

2.4.6 Injury Liability

All claims submitted with a diagnosis indicating injury will be reviewed for possible liability recoveries.

2.4.6.1 Confirming the Facts of an Injury

To prevent a claim from being denied for additional information on injuries, providers should submit letters of denials, maximums met, no liability, or other documentation, and include the following information with the claim:

- How the injury occurred
- Where the injury occurred (home, someone else's home, work, commercial property, auto, etc.)
- When the injury occurred
- Name and phone number of attorney, if applicable

Indicate the information in field 19 of the CMS 1500, field 84 of the UB92, or field 61 of the 1999 ADA claim forms. If the injury is not accident related, make note of this on the claim.

2.4.6.2 Injury Diagnosis

Investigate all possible third party involvement when a claim is denied due to injury diagnosis. Contact the participant and request additional information about the circumstances of the injury.

To process injury diagnosis claims, include the following information:

- Date of injury
- How injury occurred
- Indicate *"No TPL"* if investigation reveals no third party liability

Include all documentation regarding the injury with the claim or on the electronic claim record, even if there are several claims for the same injury. Claims are reviewed separately and each stands on its own merit.

If investigation reveals no third party liability or shows the claim is not accident related, resubmit the claim to Medicaid for reconsideration. Include information regarding attempts made to identify a third party or accident information. The information must include that at least three attempts were made.

Document the person(s) to whom the provider spoke and the date and time of the contacts. Indicate this information in field 19 of the CMS 1500, field 84 of the UB92, or field 61 of the 1999 ADA claim forms. This information may also be listed in the first comment field of an electronic claim.

2.4.7 Litigation Cases

There are two options for third party recovery cases that are in or going to litigation:

- Submit the claim to Medicaid with litigation details including the name of the attorney, if available. Medicaid will pay up to the allowed amount for the services billed.

- File a lien with the attorney for your charges. When a settlement has been reached, the provider may be reimbursed for the full amount of the charges, depending on the settlement amount and other liens or subrogations that may take precedence. When a provider chooses to bill the attorney and if a settlement occurs, regardless of the settlement amount, the provider **may not** bill Medicaid for those services after the one year billing date or if the provider receives a settlement.

Note: Medicaid payment is payment in full and providers may not collect from the settlement at a later date. Submit claims to Medicaid within the one-year billing limit.

2.4.8 TPR Inquiries

Direct inquiries regarding third party recovery and insurance information to PCG:

Write to: **PCG**
P.O. Box 2894
Boise, ID 83701

Or call: (208) 375-1132 from the Boise calling area, or
(800) 873-5875 outside the Boise calling area

Monday through Friday (excluding holidays) from 8 a.m. – 5:30 p.m. MT

2.5 Crossover Claims

2.5.1 Overview

When a participant has both Medicare and Medicaid they are considered 'dually eligible'. Bill Medicare before submitting a claim to Medicaid. Claims paid first by Medicare and then by Medicaid are called *crossover claims*.

A participant's Medicare information is available by calling MAVIS and choosing the "other insurance" menu option.

Each claim form must be submitted with a Medicare Remittance Notice (MRN) attached. The MRN must clearly state what was applied to the Medicare payment and any adjustments. Medicaid will pay at a maximum the difference between the Medicare payment and the Medicaid allowed amount or the Medicare co-insurance and/or deductible, whichever is less.

If the MRN does not clearly identify that it is a MRN, write on the top right margin of the page *'Medicare MRN'* to help sort the claim or *'Medicare HMO'* if applicable.

Out of state providers must first bill the Medicare carrier and then submit crossover claims on paper. A copy of the MRN showing payment or denial of services must be included.

Note:
Participants do not have to be 65 years old or older to be eligible for Medicare

See **Section 1.4.4** for more information on Medicare eligibility.

2.5.2 Billing Medicare

Providers must bill Medicare first for services rendered to participants who are both Medicare and Medicaid eligible.

2.5.2.1 Part A Crossover Claims — Hospital

Providers must bill Medicare Part A intermediaries before billing Idaho Medicaid.

2.5.2.2 Part B Crossover Claims — Hospital

Hospitals submitting claims for Part B only participants must first bill the Medicare carrier for any Part B services before billing Idaho Medicaid.

Part B services include:

- Laboratory
- Radiology
- Nuclear medicine
- EKG
- Speech therapy
- Physical therapy
- Prosthetic devices
- Pulmonary function tests

- Surgical supplies
- Catheters

2.5.2.3 Split Claims

Sometimes claims are billed to Medicare with more lines than will fit on the Medicaid **paper** claim form. To create a matching claim, the claim must be 'split'.

If the Medicare MRN has more detail lines than will fit on the claim form, split the claim. Submit two claims with the first lines on one claim form and the remaining lines on additional claim forms.

Write '*Split Claim'* in field 19 of the CMS 1500 or in field 84 of the UB92. Leave the fields for amount paid and balance due blank. Attach a separate copy of the EOMB to each split claim. Total each claim.

When billing electronically, it is not necessary to split a claim unless the provider is submitting more than the maximum number of details allowed on the claim.

- Dental claims: up to 50 details
- Professional claims: up to 50 details
- Institutional claims: up to 999 details

2.5.3 Crossover Errors

Occasionally, a claim does not automatically cross over to EDS. This occurs when the Medicare and Medicaid participant numbers on file do not match. If a claim does not appear on the Medicaid remittance advice (RA) within four weeks after Medicare payment, submit the claim on paper for processing. Call EDS Provider Enrollment to verify that all provider numbers are on file to allow for automatic crossover.

2.5.4 Resubmitting Crossover Claims

Crossover claims returned to the provider for any reason must be resubmitted electronically or on paper. Attach the original claim and any other supporting documentation to a copy of the Medicare Remittance Notice (MRN). Be sure to include your provider number and the participant's Medicaid identification (MID) number.

The claim dates of service, billed amounts and the MRN must match. Occasionally, Medicare combines or splits claims to expedite processing. When this happens, change the Medicaid claim form to match the Medicare remittance. The services Medicare processes as a single claim under one claim number must match exactly the service billed on the claim submitted to Medicaid.

Lab services are usually paid at 100 percent of the approved amounts. The claim total will differ from the total billed on the MRN if you do not bill these charges to Medicaid. A notation on a claim (field 19 of the CMS 1500) stating that the lab charges were paid reduces the chance of a claim being returned in error.

Note: Providers who qualify for Medicare payment but have not applied with Medicare must secure a Medicare provider number and bill Medicare before billing Medicaid for all Medicare-covered services. See **Section 2.5.9** for Medicare phone numbers and addresses.

2.5.5 Qualified Medicare Beneficiaries Medicare/Medicaid Billing Information

Participants who are only enrolled as Qualified Medicare Beneficiaries (QMBs), are only eligible for Medicare covered services up to Medicare's allowed amount from Idaho Medicaid. Claims filed secondary to Medicare are called "crossover claims." On the Medicaid Remittance Advice (RA), the payment of these charges appears on the first detail line of the paid claim on the "Professional Crossover Claim" page.

Services denied or not covered by Medicare for QMB participants will be denied if billed to Medicaid. Services denied or not covered by Medicare for clients who are 'dually eligible' may be submitted electronically or on a separate paper form. These claims are not considered crossover claims. Medicaid processes these charges as the primary payer.

For more information

see **Section 1.4.4** for Medicare Savings program descriptions

Each claim form must be submitted with a Medicare Remittance Notice (MRN) attached. All crossover claims submitted on paper must match the Medicare MRN exactly.

When a MRN contains covered and non-covered services (for dually eligible QMB participants only), submit two separate claims to Medicaid — one claim for the covered Medicare crossover portion with the MRN attached and a second claim for the non-covered Medicare services with the MRN denial attached.

Indicate *"Medicare non-covered benefit"* in comments or remarks field of your claim form.

2.5.5.1 Electronic Crossover Claims

Medicare Part B services billed by Idaho providers cross over electronically from the Medicare intermediary and carrier to EDS. This process occurs automatically when the Medicare claim shows:

- the assignment was accepted
- the participant's Idaho MID number
- the provider's Idaho Medicaid number

Provider may submit Part B services directly to Idaho Medicaid if their software supports crossover billing.

2.5.5.2 Paper Crossover Claims

Information on crossover claims submitted on paper must match the information on the Medicare Remittance Notice (MRN) exactly. The dates of service and dollar amounts must be the same as are on the MRN. File a separate claim for each claim on the Medicare MRN. Participants with both Medicare and private insurance must have EOBs from both carriers attached to the Medicaid claim form.

When billing paper crossover claims:

- use the participant's MID number
- use the Medicaid provider number
- fill in all of the same required fields as on non-crossover claims
- sign and date all claims

- attach the MRN to the claim
- make sure all attachments are on 8½" x 11" paper

If the participant is not Medicaid eligible for a certain date of service, do not enter those charges on the claim. Put a note on the front of the claim explaining that this is why the MRN does not match the claim.

2.5.6 Medicare/Medicaid Crossover Inquiries

For inquiries regarding Medicare/Medicaid crossover claims, write or call the related intermediary listed below.

Part A Medicare:

Noridian Administrative Services
P.O. Box 6726
Fargo, ND 58108-6726

Provider (877) 908-8437
(877) 425-2371 TTY

Beneficiary (800) 633-4223
(800) 633-4227

Part B Medicare:

CIGNA
P.O. Box 22599
Nashville, TN 37202

Provider (866) 520-4007
(615) 782-4509 (toll call)

Client (800) 627-2782

CIGNA Health Care: DMERC, Region D
All durable medical equipment, immunosuppressive drugs, enternal/parenternal nutrients (PEN), prosthetics, orthotics, and supplies.

CIGNA DMERC — Region D
P.O. Box 690
Nashville, TN 37202

Provider: (866) 243-7272

Client: (800) 899-7095

2.6 Adjustments

2.6.1 Overview

When a claim is paid incorrectly, submit an adjustment request to EDS. Incorrect payments may result from changes to information received after initial payment (e.g., third party resource payments or changes in nursing home participant liability amounts), provider billing errors, or claims processing errors.

Adjustments can be done only on paid claims or paid claim details. These are claims that are listed in the "Paid Claims" section of the remittance advice (RA). For more information on RAs, see Section 4.

Providers have two years after the calendar quarter in which the payment was received to request an adjustment. In accordance with the provider agreement, providers are required to immediately repay identified overpayments.

Paid claims can be adjusted with either a paper adjustment request form or through electronic billing software. Writing *'corrected claim'* on a paper claim will not fix the earlier claim error. This new claim will be denied as a duplicate claim. Using the paper form, the provider corrects specific details. Using the electronic form, the provider voids the original claim and submits a new claim with corrected information.

Electronic Adjustments: providers can submit electronic adjustments to EDS using the EDS billing software (PES) or their vendor software. When submitting electronic adjustments, use claim frequency 8 to void a claim, and claim frequency 7 to replace a claim.

Note:
Do **not** send a copy of the RA or a copy of the original claim with the adjustment.

Additional information on claim voids and replacements for **CHIP-B** participants can be found in **Appendix B, Section B.6**.

2.6.1.1 Electronic Claim Void & Replacements

Claim void and replacements are the electronic equivalent of the paper adjustment process. Providers can submit electronic void and replacements to EDS using the EDS billing software (PES) or their vendor software. For more information on submitting electronic adjustments see the *Idaho PES Handbook* or vendor software instructions.

2.6.1.2 Paper Adjustments

Claims can be adjusted with the Adjustment Request Form. Use this form to refund an overpayment, request increased payment, or to make corrections to claim information. When completing the adjustment request form, clearly state the correct billing information for the detail or claim to be adjusted.

A copy of the paper Adjustment Request Form with full instructions can be found in the **Forms Appendix**. See the table for examples of claim errors that can be corrected on this form.

Only one claim can be corrected with each adjustment request form. See table for examples.

Error on claim	On the adjustment form state…
1. A service listed on the first detail line was billed for the wrong date.	Date on line 1 should be 11/24/2002.
2. A service listed on the third detail line was billed as 2 units, but should have been billed as 4 units.	Detail 3 was billed as 2 units; it should be 4 units.
3. A service that was not performed was incorrectly listed on the fourth detail line.	No services done for line 4. Void this detail.
4. An insurance payment was received after the claim was submitted to Medicaid.	Insurance paid $156.32.
5. A claim was billed under the incorrect provider or client number.	Please void this claim.

Note: If the above examples 1 through 4 were actually on one claim, the claim should be voided. Example 5 can never be adjusted and the claim must be voided. To do this, the provider would:

- Select the option: Please withhold overpayment in a future Medicaid warrant with an adjustment **and**
- Note on the adjustment form that the claim is to be voided.

As a result, the original claim would be voided in the following week's RA and the provider could then submit the corrected claim for payment. The corrected claim cannot be submitted until the voided claim is reported on a RA.

2.6.2 Denied Claims

If a claim is denied (appears in the "Denied Claims" section of the RA), the claim must be resubmitted with any corrections that are needed to obtain payment. EDS cannot adjust denied claims or claims in-process.

Denied claims or a denied claim detail cannot be adjusted; however they can be resubmitted, either electronically or on paper, with corrections as a new day claim. It is not necessary to adjust a denied detail line on a claim if the payment of the detail would have no effect on the payment of the other lines on the claim or would not be affected by consideration of the other lines on the claim.

Example:
On a surgical claim where one line with multiple surgeries was denied, the denied detail should be corrected and only that line resubmitted. On an inpatient hospital claim where a detail revenue code was denied that would need to be processed with the accommodation charge, the line should be corrected and resubmitted to EDS for processing as a new claim.

FORM AVAILABLE: An adjustment request form with detailed instructions is included in the Forms Appendix of this handbook.

2.6.3 Adjustment Forms

An Adjustment Request Form with complete instructions is included in the Forms Appendix of this handbook. It can be copied for use as needed.

2.6.3.1 Where to Mail an Adjustment Request

Mail all adjustment requests to:

EDS
Claims Adjustments
P.O. Box 23
Boise, ID 83707-0023

Do **not** FAX adjustment request forms. They will be returned to the sender.

2.6.4 Appeals

To request a review of the reimbursement amount of a particular service, submit a written request to the EDS Correspondence Team. Include the following:

- provider number
- reason you feel you were not properly reimbursed
- supporting documentation

EDS will review the payment amount and send a written explanation if the claim was processed correctly.

To appeal EDS' review or request a review of the reimbursement amount of a particular service, send a written request for appeal to DHW.

Include the following information with the appeal:

- copy of EDS' review notice
- copy of adjustment request form if applicable (do not send an adjustment request form if the original claim(s) was denied)
- copy of claim and all attachments or new claim for possible resubmission
- copy of RA

Medicaid will review the claim and respond in writing with the final determination.

Send appeals to:

Medicaid Claim Appeals
Attn: Office of Medicaid Automated Systems
P.O. Box 83720
Boise, Idaho 83720-0036